STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155139	A. BUILDING _____ B. WING _____	R 01/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH WOODS VILLAGE	2233 W JEFFERSON ST KOKOMO, IN 46901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for the post survey re-visit to the recertification and state licensure survey completed on 11/22/10. This visit was done in conjunction with the investigation of complaint # IN00083893. Survey dates: January 3, 4, 2011 Facility number: 000064 Provider number: 155139 AIM number: 100288770 Survey team: Tammy Alley RN TC Donna M. Smith RN Toni Maley BSW (January 3, 2011) Census bed type: SNF: 15 SNF/NF: 116 Total: 131 Census payor type: Medicare: 27 Medicaid: 84 Other: 20 Total: 131 Sample: 15 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 1-7-11 Cathy Emswiller RN	{F 000}	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Review on or after January 21, 2011. RECEIVED JAN 24 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH	
{F 315} SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	{F 315}		

approved 1/26/11 pk

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director 1-19-2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 315}	Continued From page 1 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to maintain anchored catheters in a manner to prevent the possibility of infection for 2 of 4 residents reviewed with anchored catheters in a sample of 15. (Resident # 35 and # 84) Findings include: 1. A 01/2010 policy titled "Foley Catheter care and Maintenance" was provided by the administrator on 1/4/11 at 12:15 p.m., and deemed as current. The policy indicated: "...Purpose 1. To maintain the patentcy (SIC) of an indwelling catheter and prevent the spread of infectious disease...." 2. The record for Resident # 35 was reviewed on 1/4/11 at 11:15 a.m. Current diagnoses, included, but were not limited to, urinary retention. A physician order dated 12/29/10 indicated an	{F 315}	**F315 No Catheter, Prevent UTI, Restore Bladder** This provider ensures that based on the resident's comprehensive assessment, a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** • Resident # 35 and #84 have been reassessed and have no signs or symptoms of UTI. • ADNS (Assistant Director of Nursing), UM (Unit Manager) #1 and C.N.A. (Certified Nursing Assistant) #2 have been re-educated on proper placement and handling of Urinary drainage bags and tubing procedure on 1-4-11 by DNS/Designee. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** • Residents with physician orders for indwelling catheters have the potential	

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{F 315}	Continued From page 2 order for an anchored catheter and for a urinalysis to be completed. A 12/29/10 urinalysis report indicated the resident's urine was orange, slightly cloudy, had 100 + white blood cells (normal 0-5), 25-50+ red blood cells (normal 0-5) and 2+ bacteria (normal is negative). A physician order dated 12/29/10 indicated an order for Rocephin (antibiotic) 1 gram to be given for one dose for increased white blood cells in the urine, then start Bactrim DS (antibiotic) daily for 7 days. During a personal care observation on 1/4/11 at 10:30 a.m., Resident # 35 was wheeled into the bathroom by the ADON (Assistant Director of Nursing). CNA # 2 entered the room and with ungloved hands removed the resident's anchored catheter drainage bag from the dignity bag under the wheelchair and handed it to the ADON who then place the anchored catheter drainage bag and tubing on the floor to the right side of the resident's wheelchair. She was not wearing gloves. The resident was then transferred to the toilet. Before the resident was transferred to her wheelchair from the toilet, the ADON picked up the anchored catheter drainage bag and moved it under the wheelchair, still on the floor. The resident was transferred to the wheelchair. CNA # 2 then picked up the anchored catheter drainage bag and placed it on the arm of the wheelchair, then wheeled the resident to the bedside. She had no gloves on. She then placed the anchored catheter drainage bag and tubing on the floor at the resident's bedside. The resident was then transferred to bed. CNA # 2 picked up the drainage bag and placed it in the	{F 315}	to be affected by the alleged deficient practice. • Licensed nurses and C.N.A. were re-educated on assessment, documentation, and appropriate diagnosis for indwelling catheters, proper handling of Urinary drainage bags and tubing for residents, by 1-19-2011 by the Clinical Trainer and/or DNS (Director of Nursing) Specialist. • Noncompliance with facility policy and procedure may result in employee re-education, and/or disciplinary action up to and including termination. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** • Residents will have a bowel and bladder assessment upon admission, annually and with significant change. • Resident change of status related to signs and symptoms of UTI will be placed on the 24 Hour Report Sheet by the charge nurse and the physician will be notified, as needed. • The Unit Managers and the Interdisciplinary Team will review the 24 Hour Report Sheet and new Physician Orders at the Change of Condition Meeting Monday – Friday (excluding holidays). • Licensed Nurses and C.N.A have been re-educated on proper placement of catheter drainage bag and tubing on 1-	

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{F 315}	Continued From page 3 dignity bag attached to the frame of the bed. She then covered the resident with a blanket. At that time, during interview, the ADON indicated she realized she had placed the anchored catheter drainage bag and tubing on the floor. On 1/4/11 at 1:20 p.m., during interview, CNA # 2 indicated anchored catheter drainage bags and tubing should not be on the floor. She indicated she had recently been inserviced on this. 3. On 1/03/11 from 4:25 p.m. to 4:30 p.m., Resident #84 was observed. Upon entering her room, the resident's foley catheter (F/C) tubing was observed on the floor. Cloudy, yellow urine with white sediment was observed in the tubing. As Resident #84 indicated she was ready to go downstairs to wait on her taxi, she began to wheel herself down the hallway to the elevator with the same F/C tubing dragging the floor. During this same time Unit Manager #1 was observed to pick the F/C tubing off of the floor and place it in the dignity bag under the resident's wheelchair. After going down the elevator and getting off onto the first floor, Resident #84 again was wheeling herself to the front desk with the F/C tubing again observed dragging on the floor with the same urine observed in the tubing. The Administrator was then notified of Resident #84's F/C tubing dragging on the floor. Resident #84's record was reviewed on 1/03/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to, neurogenic bladder and Diabetic Mellitus. The quarterly minimum data set assessment, dated 10/08/10, indicated the resident had an indwelling catheter. The "PLAN OF CARE," originally dated 2/01/10,	{F 315}	19-2011 by Clinical Trainer and/or DNS specialist. • DNS and ADNS will be monitoring proper procedure for catheter care and handling of drainage bags and tubing using the "Catheter Care" CQI tool, weekly times 4, than monthly times 2 than quarterly thereafter. • Noncompliance with facility policy and procedure may result in employee re-education, and /or disciplinary action up to and including termination. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** • A "Catheter Care" CQI tool will be utilized weekly x 4, monthly x 2 and quarterly thereafter, to monitor compliance with urinary catheters and proper personal care. The governing CQI committee will review the data. If the threshold for compliance is not met, an action plan will be developed. • Noncompliance with facility policy and procedure may result in employee re-education, and /or disciplinary action up to and including termination. **Compliance date: 1/21/11**	

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{F 315}	Continued From page 4 indicated the problem was risk for urinary tract infection related to the F/C. The interventions included, but were not limited to, foley catheter care and observed for signs and symptoms of urinary tract infection. This Federal Deficiency was cited on 11/22/10. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 3.1-41(a)(2)	{F 315}	**F441 Infection Control, Prevent Spread, Linens** It is the practice of this facility to maintain and Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	
{F 441} SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	{F 441}	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** • Resident # 24,35,59,84,85 receive personal care with proper infection control procedures for hand washing, glove use, handling of linen and equipment and in accordance with professional standards of care. • Residents receive care by staff that have washed their hands before and after direct care contact and per procedure policy. • ADNS, UM #1,LPN's #4 and C.N.A. #2, #3 and #5 have been re-educated to the hand washing use of gloves, handling of linen, equipment handling procedures and skills check off procedure by the Clinical Trainer and/or DNS specialist 1-19-11. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken**	

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{F 441}	Continued From page 5 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure infection control practices were followed in a manner to prevent the potential for the spread of infections and diseases concerning 5 of 5 residents (residents # 35, 24, 84, 85, 59), 3 of 4 equipment handling observations (CNA #2 and #5; LPN #4 and ADON [Assistant Director of Nursing]), concerning 2 of 3 handwashing/glove use observations during personal care (CNA #3 and #5), and concerning 2 of 3 linen handling observations during personal care (CNA #5). (Resident #'s 35, 24, 84, 85 and 59) Findings include: 1. The "Handling Clean Linen" policy was provided by the Director of Nursing on 1/04/11 at 4:10 p.m. This current policy indicated the following: "Objective To provide clean, fresh linen to each resident. To	{F 441}	• Residents who reside in the facility have the potential to be affected by the alleged deficient practice. • Upon hire nursing staff completes skills validation to ensure competency with hand washing procedures and training on proper infection control practices. • Licensed Nurses and C.N.A. have been re-educated on Infection Control Practices and had skills check off completed for hand washing, linen handling, handling catheter drainage bags and tubing and equipment handling 1-19-11 by Clinical Trainer and/or DNS specialist. • Noncompliance with facility policy and procedure may result in employee re-education, and/or disciplinary action up to and including termination. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** • The nursing managers and department heads monitor resident rooms and common areas for infection control practices Monday – Friday, excluding holidays. The nurse manager on duty monitors the facility for appropriate infection control procedures during weekends. A report is provided to the CQI committee no less than monthly. • The Infection Control nurse, and/or designee, monitors for infection	

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{F 441}	Continued From page 6 prevent contamination of clean linen. ...Important Points ...Carry linen away from body/uniform....." 2. A 01/2010 policy titled "Hand Washing Policy & Procedure" was provided by the administrator on 1/4/11 at 12:15 p.m., and deemed as current. The policy indicated: "...3. When washing hands with soap and water, wet hands first with water, apply soap and rub hands together vigorously for at least 20 seconds...covering all surfaces of the hands and fingers...3. Decontaminate hands before and after having direct contact with patients including intact skin such as taking a pulse, blood pressure and lifting patients. 4. Decontaminate hands before donning gloves...this includes the changing of gloves in the middle of any procedure. 5. Decontaminate hands in moving from a contaminated-body site to a clean body site during patient care. 6. Decontaminate hands after contact with inanimate objects (including medical equipment...." 3. During a personal care observation on 1/4/11 at 10:30 a.m., Resident # 35 was wheeled into the bathroom by the ADON (Assistant Director of Nursing). CNA # 2 entered the room and with ungloved hands removed the resident's anchored catheter drainage bag from the dignity bag under the wheelchair and handed it to the ADON who then place the anchored catheter drainage bag and tubing on the floor to the right side of the resident's wheelchair. She was not wearing gloves. The resident was then transferred to the toilet. Before the resident was transferred to her wheelchair from the toilet, the ADON picked up the anchored catheter drainage bag and moved it	{F 441}	Noncompliance with facility policy and procedure may result in employee re-education, and/or disciplinary action up to and including termination. • The Infection Control nurse, and/or designee, monitors for infection control related to nursing practice. Areas of noncompliance are addressed with the charge nurse and/or certified nursing aide through re-education and/or disciplinary action, as needed. The information is reported to the Director of Nursing Services and CQI Committee monthly, and as needed. • Employees are educated on Infection Control Practice upon hire and no less than annually, and as needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** • An "Infection Control Review" CQI tool will be utilized weekly x 4, and monthly, to monitor compliance with hand washing, gloving, linen and equipment handling. The governing CQI committee will review the data. If the threshold for compliance is not met, an action plan will be developed. **Compliance date: 1-21-11**	

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{F 441}	Continued From page 7 under the wheelchair, still on the floor. The resident was transferred to the wheelchair. CNA # 2 then picked up the anchored catheter drainage bag and placed it on the arm of the wheelchair, then wheeled the resident to the bedside. She had no gloves on. She then placed the anchored catheter drainage bag and tubing on the floor at the resident's bedside. The resident was then transferred to bed. CNA # 2 picked up the drainage bag and placed it in the dignity bag attached to the frame of the bed. She then covered the resident with a blanket. At that time, during interview, the ADON indicated she realized she had placed the anchored catheter drainage bag and tubing on the floor. On 1/4/11 at 1:20 p.m., during interview, CNA # 2 indicated anchored catheter drainage bags and tubing should not be on the floor. She indicated she had recently been inserviced on this. 4. During a nebulizer treatment observation with LPN # 4 on 1/3/11 at 1:30 a.m., LPN # 4 entered resident # 24's room. She placed the pulse oximeter, her stethoscope, and note paper and pen on the resident's bed. She set up the treatment. She then used the stethoscope to check the residents lung sounds. When she was finished she placed the stethoscope around her neck, draping onto her uniform. When the nebulizer treatment was completed, she picked up her notepaper, pen and oximeter and went to the bathroom to wash her hands. She placed the notepaper and pen on the back of the toilet and place the oximeter on the note paper. She then washed her hands for less than 5 seconds. Her pen fell into the trash can and she picked it up and place it on the notepaper. She again washed	{F 441}		

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{F 441}	Continued From page 8 her hands for less than 15 seconds. She picked up the oximeter, the notepaper and her pen and went to medication cart where the items were placed. 5. On 1/03/11 from 4:25 p.m. to 4:30 p.m., Resident #84 was observed. Upon entering her room, the resident's foley catheter (F/C) tubing was observed on the floor. Cloudy, yellow urine with white sediment was observed in the tubing. As Resident #84 indicated she was ready to go downstairs to wait on her taxi, she began to wheel herself down the hallway to the elevator with the same F/C tubing dragging the floor. During this same time Unit Manager #1 was observed to pick the F/C tubing off of the floor and place it in the dignity bag under the resident's wheelchair. After going down the elevator and getting off onto the first floor, Resident #84 again was wheeling herself to the front desk with the F/C tubing again observed dragging on the floor with the same urine observed in the tubing. The Administrator was then notified of Resident #84's F/C tubing dragging on the floor. 6. On 1/03/11 from 10:28 a.m. to 10:55 a.m., Resident #85's personal care was observed. In preparation, CNA #3 was observed to obtain clean linen and intermittently switch the linen from her arm to the top of the Broda chair. Initially on her arm, the linen rested up against her uniform. As CNA #3 switched the linen to the top of the Broda chair, she pushed the chair toward the resident's room with the linen over the top of the chair next to her uniform. With this same linen the resident's bed was made. After transferring the resident per Hoyer lift from her Broda chair to the bed, CNA #3 with gloved hands removed the resident's brief. CNA #3	{F 441}		

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{F 441}	Continued From page 9 indicated the resident had been incontinent of urine and small amount of bowel movement. After cleaning the rectal area of bowel movement, CNA #3 with the same gloves applied protective cream to the resident's buttocks before removing her gloves and washing her hands. At this same time during an interview, CNA #3 indicated she should had changed gloves prior to applying the resident's cream to her buttocks due to she could be putting bacteria from the rectum back on the resident. She also indicated soiled and/or clean linen should be carried away from one's uniform. 7. On 1/03/11 from 11:05 a.m. to 11:17 a.m., Resident #59's personal care was observed. After preparations were completed, CNA #5 with gloved hands completed the resident's peri-care and then, rectal care. During this same care, CNA #5 was observed with the same gloved hands to turn the bed alarm, which was sounding with the resident's repositioning, off several times. Also, CNA #5 with the same gloves applied protective cream to the resident's buttocks before removing her gloves and handwashing. At this same time during an interview, CNA #5 indicated she should had changed her gloves prior to applying the protective cream to the resident's buttocks. This Federal Deficiency was cited on 11/22/10. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 3.1-18(l) 3.1-19(g)	{F 441}		

F 441

Continuous Quality Improvement

Quality Indicator: Infection Control Review

Compliance = # of yes responses x 100 Percentage of Compliance_____ Signature of Assessor/Date:_____

Criteria/Questions	Yes	No	Comments
Proper hand washing techniques are observed by staff (check dining room, medication pass, resident care)			
Gloves are worn when there is contact with blood, specimens, tissue, body fluids, or excretions			
Gloves are changed and hands washed between resident contacts			
Precautions are observed for the disposal of soiled linens, dressings, disposable equipment (sharps), and for the cleaning of contaminated equipment			
Linens and laundry are handled or transported in a manner to prevent the spread of infection (covered in hallways)			
Isolation precautions are implemented when it is determined that a resident needs isolation with order written			

F 315

Catheter assessment

Criteria/Questions	1	2	3	4	5	6	7	8	9	10	Comments
The catheter is present on the care plan and the aide assignment sheet											
A 3 day voiding pattern is initiated upon removal of a catheter.											
The resident is monitored for voiding following catheter removal---within 8 hours of catheter removal or per physician order											
Catheter bags remain covered and maintained below the level of the bladder no tubing on floor											
Catheter tubing is not touching or dragging on the floor											
Cylinders to empty catheter are kept in plastic bags in resident room and not in shared bathroom											
Urine is clear and without any evidence or signs of infection (if + or those reported to the physician)											

F 315
F 441

Incontinence

Criteria/Questions (page 2 of 2)	Residents 1	2	3	4	5	6	7	8	9	10	11	Comments
Does care plan address resident's individual toilet needs												
Does staff maintain dignity/privacy during resident toileting												
Are residents checked at least every two hours or per individualized toileting need												
Are residents in bed without incontinent briefs on (unless family/res requests them to be on												
Does care plan specify family/resident preference for incontinent brief usage												
* Is resident provided incontinent care with appropriate products after each toileting episode (per facility policy)												
* Does staff use appropriate infection control procedure while providing incontinent care Proper Peri Care.												
Is there documentation to support staff is providing adequate hydration												
* proper linen handling												

Compliance: Count only yes/no boxes for Total # of completed boxes
Any question that does not apply to specific quality indicator use N/A in box and do not count in completed boxes

From ISDH
CNA core Curriculum

TOPIC 14: RESIDENT ENVIRONMENT

1. **The resident environment includes the facility, the grounds and especially the resident's room.** When a resident enters a long-term care facility, he or she experiences the loss of home and belongings. The staff's goal is to help each resident make the room his or her own. Familiar things create a positive environment.

2. **The resident's room contains all of the things necessary to make the resident feel safe and comfortable and usually includes the:**
   a. Bed - types of beds may vary in each facility. Most beds have controls to raise, lower and adjust positions. Some facilities may allow the resident to bring a bed from home.
   b. Side rails - half or full rails attached to the sides of the bed considered:
      1. A self-help aid to assist the resident with mobility.
      2. A safety device, and should be up if the bed is raised.
      3. A restraint if used for the sole purpose of confining the resident in bed and requires a doctor's order.
   c. Overbed Table – narrow table on wheels with adjustable height, which can be pushed over the bed and used for eating, writing and other activities.
   d. Bedside Stand - storage area for personal care items and personal belongings.
   e. Cushioned comfortable chair - for use by visitors or residents.
   f. Curtains or Screens - can be pulled around bed as needed to provide for a resident's right to privacy.
   g. Personal Care Items – may include a wash basin, emesis basin, soap dish, bedpan and/or urinal.
   h. Call System – used by the resident to request assistance - *must* be on the resident's unaffected side and within reach whenever the resident is alone in the room or the bathroom.

3. **A comfortable environment may positively affect how the resident feels physically and emotionally and improve the resident's sense of well being:**
   a. Temperature - the resident's condition and preferences should determine the appropriate temperature.
   b. Light - indirect lighting is preferable because glare causes fatigue. If more light is needed for a procedure, turn the added light off when the procedure is completed.
   c. Ventilation - good air circulation helps control odors and reduce pathogens. Promptly remove odor-causing waste.
   d. Floors - wipe up spills immediately. Keep floors clean and free from clutter to provide for safety.
   e. Noise - interferes with rest, which is important for health and recovery. Keep equipment in good condition and handle equipment quietly.
   f. Water - fresh water should be placed on the resident's unaffected side and within reach to ensure adequate hydration unless contraindicated by the resident's care plan.
   g. Equipment - Always report unsafe equipment and conditions to the nurse immediately.

4. **The Resident needs a clean, neat, wrinkle-free bed for comfort and dignity and to prevent skin irritation and skin breakdown.**
   a. When making a bed:
      1) Carry clean or dirty linens away from your uniform. Place clean linen on a clean surface. Never place dirty linens on the floor, which can spread infection and pose a safety hazard.
      2) Use good body mechanics.
      3) Dispose of soiled linens properly.
      4) Make sure bottom layers of linen are wrinkle-free.
      5) Make one side of the bed at a time. It is quicker, more efficient and conserves energy.

Standard Precautions

Standard

Standard Precautions is an isolation/precautionary system using appropriate barriers, as needed, to prevent the transmission of infectious organisms.

Policy

The facility shall adopt Standard Precautions in the care of all residents, combining the standard isolation goal of resident protection with the employee protection goal of Universal Precautions (UP).

Procedures

A. Universal Precautions require the use of barriers (personal protective equipment) to reduce the employee's risk of occupational exposure to blood, body fluids containing visible blood, tissue, and certain other body fluids:

Cerebrospinal fluid	Synovial fluid
Pleural fluid	Peritoneal fluid
Pericardial fluid	Amniotic fluid

Universal Precautions do not apply to feces, nasal secretions, sputum, sweat, tears, urine, and vomitus (unless they contain visible blood).

B. Medical history and examination cannot reliably identify all persons:
- With infectious organisms but without clinical signs and symptoms
- Colonized by antibiotic-resistant strains (such as MRSA)

C. Standard Precautions considers all moist body substances as potentially infectious, including:

Pus	Feces	Sputum	Semen
Urine	Blood	Saliva	Vaginal secretions
Vomitus	Wound Drainage	Tears	Mother's milk

(Sweat is not considered potentially infectious unless it is mixed with other secretions)

D. Standard Precautions requires the use of appropriate barriers (personal protective equipment) when healthcare giver's:
- Hands are likely to contact mucous membranes, non-intact skin, or moist body substances (i.e., pus, urine, sputum, feces, blood, saliva, etc).
- Eyes, nose, mouth, or clothing are likely to be splattered or soiled by moist body fluids.

E. Standard Precautions requires **handwashing**, which is vitally important to infection control.

F. Elements of Standard Precautions are to be followed by personnel at all times while in the role of healthcare giver or other department providing services in the facility.

1. Gloves
   a. Wear when hand contact is reasonably anticipated with resident's mucous membrane, non-intact skin, and/or moist body substances OR item, surfaces soiled by them.
   b. Use examination gloves unless procedure requires sterile gloves.
   c. Change between residents or sooner when visibly soiled.
   d. Do NOT handle medical equipment, or other devices with contaminated gloves.
   e. Wash hands after removing gloves.

2. Handwashing
   a. Wash hands often and well, per Handwashing procedure.

3. Face, Eye Protection
   a. Wear mask or eye protection when splash/splatter of body substances is likely: irrigating wounds, emptying fluid containers, suctioning resident with copious secretions..

4. Apron or Gown
   a. Protect clothing with a plastic apron or gown when soiling of clothing is likely.

5. Sharps: Handling and disposal (same as UP)
   a. Do not recap, bend, or cut needles
   b. Dispose of needles in a puncture-resistant container

6. Laboratory Specimens (same as UP)
   a. Place specimens in leak-proof containers
   b. Color-coded or label per UP

G. Handle soiled linen and waste per facility policies (if UP are used, no special handling of soiled linen is required).

H. Handle blood spills per UP and facility policy.

I. A private room may be requested (cohorting acceptable) for:
   1. Diseases transmitted primarily by airborne route, including certain respiratory infections or suspected/known TB (cohorting not acceptable).

   2. Residents unable or unwilling to cooperate with good hygiene practices: soiling room, surfaces with body substances.

   3. Multiple, uncontained wounds infected with resistant organisms, such as MRSA

   4. Infections specified by regulatory agency. Consistent, reliable application of Standard Precautions concept will prevent the spread of infections.

J. Signage
   1. Place a standard sign in all resident-care areas explaining that Standard Precautions is used in the care of all residents.
   2. Place a STOP sign on a room used for respiratory infections.
   3. Place a STOP sign on a room for Transmission based precautions.

K. Recognize that Standard Precautions:
   1. Prevents the spread of infection.
   2. Is less traumatic to resident's emotional and social needs.
   3. Is easier to understand.
   4. Compliance can be easily monitored

Note: See Standard Precautions Isolation: Rationale, next page.

American Senior Communities	Hand Washing Policy & Procedure	
Section: Nursing Policy and Procedure	Original Date: 01/2010	

Policy: Hand Washing Procedure

A. Purpose

1. To prevent the spread of infectious disease

B. Equipment

1. Soap
2. Water
3. Hand towel
4. Alcohol gel

C. Definition

1. Decontaminating hands can refer to washing with soap and water or using alcohol gel intermittently in place of soap and water.
2. When decontaminating hands with an alcohol-based hand rub, apply the product to palm of one hand and rub hands together, covering all the surfaces of hands and fingers, until hands are dry.
3. When washing hands with soap and water, wet hands first with water, apply soap and rub hands together vigorously for at least 20 seconds (Centers for Disease Control [CDC], 2010) covering all surfaces of the hands and fingers. Rinse hands with water and dry thoroughly with a disposable towel. Use towel to turn off the faucet.

D. Procedure

1. When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other bodily fluids, wash with soap and water.
2. If hands are not visibly soiled, use soap and water or an alcohol-based hand rub for routinely decontaminating hands.
3. Decontaminate hands before and after having direct contact with patients including intact skin such as taking a pulse, blood pressure and lifting patients.
4. Decontaminate hands before donning gloves (clean or sterile) *this includes the changing of gloves in the middle of any procedure.
5. Decontaminate hands if moving from a contaminated-body site to a clean body site during patient care.
6. Decontaminate hands after contact with inanimate objects (including medical equipment).
7. Before eating and after using the restroom, wash hands with soap and water.

Reference:

Center for Disease Control (2002). Morbidity and Mortality Weekly Report. *Guideline for Hand Hygiene in Health-Care Settings*, 51, 34-35.

American Senior Communities	Peri-Care	
Section: Nursing Policy and Procedure	Original Date: 01/2010	

A. **Purpose**

1. To cleanse the perineum for prevention of infection, irritation and to contribute to the resident's positive self-image

B. **Equipment**

1. Washcloth or disposable wipes and towel
2. Incontinence product (brief, pad, liner, etc) if applicable
3. Peri wash or soap
4. Wash basin
5. Gloves
6. Bags for disposal of trash and laundry

C. **Procedure**

1. Verify resident and explain procedure
2. Obtain necessary equipment and provide for privacy
3. Wash hands
4. Position resident in supine position
5. Apply gloves
6. Remove disposable brief or pad
7. Wipe off any excess feces with toilet paper or clean area of brief or pad
8. Roll the brief or pad up to ensure the inside contents are contained
9. Place brief or pad in plastic bag
10. Remove soiled gloves and wash hands
11. Fill basin with warm water or wet clean cloth with warm water from sink.
12. Apply clean gloves
13. Female: Using peri care product and wet wash cloth, wash labia first. Always wash from front to back. Be sure to spread the labia and cleanse thoroughly. Rinse and dry completely. Turn resident to the side and cleanse anal area thoroughly. Rinse and dry completely
14. Male: Wash from front to back, using peri care product or soap. Be certain to pull the foreskin of penis back for cleansing (if male is uncircumcised). Rinse and dry thoroughly. Turn resident to side and cleanse anal areas thoroughly. Rinse and dry completely.
15. Place soiled wash cloth in bag
16. Remove gloves and wash hands
17. Apply appropriate brief product and/or clothing
18. Make resident comfortable
19. Handle and dispose of soiled brief/linen appropriately and wash hands
20. Report and document any pertinent information

American Senior Communities	Foley Catheter Care and Maintenance	
Section: Nursing Policy and Procedure	Original Date: 01/2010	

Policy: Foley catheter care and maintenance

A. **Purpose**
   1. To maintain the patentcy of an indwelling catheter and prevent the spread of infectious disease

B. **Frequency**
   1. Q-shift

C. **Equipment**
   1. Gloves
   2. Wash cloth
   3. Soap, water and basin
   4. Collection container
   5. Goggles
   6. Trash bag

D. **Procedure for providing catheter care**
   1. Identify the patient
   2. Explain the procedure
   3. Drape the patient with a sheet to ensure privacy
   4. Wash hands and gather equipment at the residents bedside placing a collection bag at the foot of the bed for soiled linens
   5. **Note:** refer to peri-care procedure in addition to Foley catheter care
   6. **Male & Female** - using the non-dominant hand grasp the catheter tubing several inches from where it enters the meatus. Using the dominant hand retrieve a wet soapy wash cloth and gently wash the catheter beginning at the meatus and working away from the body. Change area on the washcloth or retrieve a new washcloth for consecutive passes along the catheter tubing.
   7. Place soiled wash cloth in plastic bag
   8. Prevent from pulling on catheter as much as possible during this procedure.
   9. Provide full privacy for patient by covering or re-dressing
   10. Dispose of materials in proper receptacle
   11. Wash hands

E. **Procedure for emptying a urinary catheter bag**
   1. Identify the patient
   2. Explain the procedure
   3. Pull the curtain to ensure privacy
   4. Wash hands and gather equipment at the residents bedside placing a collection/measuring container near the urine collection bag
   5. Wash hands and apply gloves

6. Place paper towel on the floor and measuring container on top of paper towel
7. Position the collection container under the collection bag drain tube
8. Ensure the drain tube is inserted into the measuring container and the measuring container is aimed away from the health care worker to prevent splashing. If this task cannot be performed then the health care worker should wear goggles to prevent splashing of urine into the eye(s)
9. Open the drain clamp
10. Empty the urine and close the clamp
11. Replace the catheter bag into a privacy bag
12. Measure the urine and dispose of waste in receptacle and toilet as needed
13. Rinse the measuring container dumping the rinse into the toilet and place container into plastic bag for next use
14. Remove gloves and wash hands
15. Inform the charge nurse of the amount of urine that was emptied

TOPIC 25: ELIMINATION

1. **Elimination is the process of ridding the body of waste through urination and defecation.**
   a. Urine – a liquid waste secreted by the kidneys every two to eight hours. Normal urine is pale yellow, clear and free of particles, blood and pus. The act of urination may be called voiding.
   b. Feces (stool, bowel movement) – a semisolid waste from the digestive tract passed through the anus as frequently as one to three times per day or as infrequently as two times per week. Feces should be medium brown and free of blood or mucous.

2. **To assist the resident to maintain normal elimination:**
   a. Provide and properly use equipment (urinal, bedpan, fracture pan, bedside commode, toilet).
   b. Assist the resident to a position that is as normal as possible (Raise head of bed to sitting position. Have men stand to urinate if possible).
   c. Check residents frequently for elimination needs.
   d. Provide privacy and enough time to eliminate. If the resident is stable leave the immediate area.
   e. Report complaints or observations of diarrhea or constipation.
   f. Encourage good nutrition, and adequate fluids and exercise.
   g. Always wipe from cleanest to dirtiest (front to back).

3. **Incontinence** is the inability to control bowel and/or bladder function. Causes include injury, disease, infection, certain medications and lack of access to toilet facilities.
   a. To meet the needs of the incontinent resident the CNA must:
      1) Respond to call light immediately.
      2) Check resident often for wetness and soiling. Provide frequent perineal care and skin care.
      3) Use incontinence briefs according to manufacturer's guidelines. Check for fit and keep plastic side away from skin.
   b. **Bowel and bladder training programs** may be ordered for the incontinent resident to help improve control of elimination. The CNA should:
      1) Follow elimination schedules exactly as the nurse instructs.
      2) Document success or lack of success accurately. Training does not happen overnight.
      3) Work cooperatively with team members. Continuity is vital.
      4) Be supportive and sensitive.

5. A **urinary catheter** is a tube inserted by the nurse through the urethra into the bladder to drain urine. An indwelling catheter is left in the bladder continually. The CNA's should:
   a. Keep drainage bag below level of bladder to allow gravity flow.
   b. Check tubing for kinks, blockages and signs of leakage.
   c. Place tubing over, never under, leg to prevent pressure sores.
   d. Attach bag to bed frame, never to guard rail. Keep bag and tubing off floor.
   e. Consider urinary drainage system whenever moving or transferring resident.
   f. Clean catheter from meatus out.
   g. Empty drainage bag and measure amount of urine at least once every shift and document observations.
   h. Use leg straps according to manufacturer's instructions.

6. **CNA's role:**
   a. Provide for the resident's privacy during elimination.
   b. Respect the resident's right to confidentiality if the resident is incontinent.
   c. Clean an incontinent resident immediately to prevent skin breakdown.
   d. Follow Standard Precautions when performing elimination related procedures.
   e. Assist residents to wash their hands after elimination.

American Senior Communities	**Gloves**	
Section: Nursing Skills Validation	Original Date: 02/2010	

Skill	**Y or N**	
Wash Hands		
Put on Gloves		
Check for tears		
Perform procedure		
Remove one glove in your gloved hand		
Place two fingers of ungloved hand under cuff of other glove and pull down so first glove is inside second glove		
Dispose of gloves without contaminating hands		
Wash hands		
Insulin mixed prior to drawing up by rolling between the palms gently		
PRN medication administered authorized by a licensed nurse if given by QMA		
Licensed nurse assessed resident to determine the need for the PRN medication		
QMA documents reason for giving & effectiveness with licensed nurse co-sign		
Med room and med/tx carts locked when unattended		

Comments:	
Nurse sign/date:	
Instructor sign/date:	

American Senior Communities	**Hand Washing Skills Check**	
Section: Nursing Skills Validation	Original Date: 02/2010	

Skill:	**Y or N**	
Turns on water to Acceptable temperature		
Angle arms down holding hands lower than elbows. Wet hands and wrists		
Apply soap to hands		
Lather all areas of hands and wrists, rubbing vigorously for at least 20 seconds		
Clean nails by rubbing them in palm of other hand		
Rinse thoroughly, running water down from wrist to fingertips		
Pat dry with paper towel		
Turn off faucet with paper towel and discard towel immediately		

Comments:	
Nurse sign/date:	
Instructor sign/date:	

American Senior Communities	Perineal Care	
Section: Nursing Skills Validation	Original Date: 02/2010	

Skill	Y	or N
Identify Resident and Explain Procedure		
Provide for Privacy		
Wash hands		
Assist resident to supine position and drape		
Fill wash basin with warm water and have resident check water temperture		
Put on gloves		
Assist resident to spread legs and lift knees if possible		
Wet and soap folded washcloth		
If resident has catheter, check for leakage. Secretions or irritations. Gently wipe four inches of catheter from meatus out		
Wipe from front to back and from center of perineum to thighs. Change washcloth as necessary.		
For Females: Separate labia. Wash urethral area first; wash between and outside labia in downward strokes, alternating from side to side and moving outward to thighs. Use different part of washcloth for each stroke		
For Males: Pull back foreskin if male is uncircumcised. Wash and rinse the tip of penis using circular motion beginning at urethra. Continue washing down the penis to the scrotum and inner thighs		
Change water in basin. With a clean washcloth, rinse area thoroughly in the same direction as when washing		
Gently pat area dry in same direction as when washing		
Assist resident to turn onto side away from you		
Wet and soap washcloth		
Clean anal area from front to back, rinse and pat dry thoroughly		
Assist resident to turn onto back and undrape resident		
Remove gloves		
Wash hands		
Report any unusual findings to nurse		
Document procedure		

Comments:	
Nurse sign/date:	
Instructor sign/date:	

American Senior Communities	Foley Catheter Care and Maintenance Emptying Urinary Drainage Bag	
Section: Nursing Skills Validation	Original Date: 02/2010	

Skill **Foley Catheter Care**	Y	or N
Confirms patient ID		
Explain procedure to resident		
Drape the resident for privacy		
Gather equipment		
Wash Hands		
Provide collection bag at foot of bed for soiled linen		
Provide Peri-care per standard		
Male/Female: Using non-dominant hand grasp the catheter tubing several inches from where it enters the meatus. Using the dominant hand retrieve a wet soapy wash cloth and gently wash catheter starting at meatus and working out.		
Place soiled wash cloth in plastic bag		
Provide full privacy for resident by covering or redressing		
Dispose of materials in proper receptacle		
Wash Hands		
Document pertinent information		
Emptying Urinary Catheter Bag:		
Confirm resident		
Explain procedure		
Provide privacy		
Gather Equipment and Wash Hands		
Apply gloves		
Place paper towel on floor and measuring container on top of paper towel		
Position the collection container under urinary drainage bag drain tube		
Ensure the drain tube is inserted into the measuring container		
Open the drain clamp		
Empty urine and close clamp		
Replace catheter bag into privacy bag		
Measure urine and dispose of waste in receptacle and toilet as needed		
Rinse the measuring container and place in plastic bag		
Remove gloves and wash hands		
Document and report pertinent information		

Comments:	
Nurse sign/date:	
Instructor sign/date:	

Pre/Post Test for Infection Control, Peri-Care, Foley Catheter Care, & Linen Handling

Name:_____ **Date:**_____

1. **The proper technique for peri-care is to wash from front to back.** **T or F**

2. **Peri-Care is the same for males & females.** **T or F**

3. **What is the single most important factor in preventing the transmission of infections?**

4. **Always replace the foreskin on the penis after completing peri-care.** **T or F**

5. **Closing the door and pulling the curtain provides for privacy.** **T or F**

6. **Peri-Care should be provided with every incontinent episode.** **T or F**

7. **Hands should be washed for at least 20 seconds.** **T or F**

8. **Medical equipment (thermometer, stethoscope, pulse oximeter, bedpan or urinal) can be placed on any surface without a barrier.**
T or F

9. **When should hands be washed? List 3:**

10. **Urinary drainage bags are to be kept below bladder level & off the floor during transfers.**
T or F

11. **Good peri-care helps prevent urinary tract infections.** **T or F**

12. **Clean or dirty linens should be carried away from your uniform.** **T or F**